Tennessee Department of Children's Services

Community Residential Facility Medication Administration Record

Name:____ Facility: ____

Allergies:______________________________________ Month: ____________________ Year: ________________

START	STOP	Medications	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		Dr.																																
		Start #																																
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		Dr																																
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Initials	Staff Signature	Initials	Staff Signature	Initials	Staff Signature

Codes: ☐ **R=Refusal** ☐ **N/S =No Show** ***Check Box to Indicate Code***

☐ **D/C = Discontinued** ☐ **H= Medical Hold**

Comments: ____

____

Reviewer's Signature: ____

OVER THE COUNTER MEDICATIONS

Name:_____Location:_____

Date	Time	Medication/Dosage/Route of Administration	Reason	Full Legal Signature

Reviewer's Signature: _____